

**Informational Hearing
Assembly Health Committee
Dave Jones, Chair**

The Environment for State Health Reform: What is Next?

**Tuesday, March 10, 2009
1:30 p.m. – 3:45 p.m.**

**State Capitol
Room 4202**

Many state and federal health care reform efforts have focused on coverage – what to do about the uninsured. The current discussions at the federal level, and in many states, have increasingly also focused on the interrelated issues of *coverage*, *cost* and *quality* and the growing awareness that the health care delivery system – not just the health care coverage system, needs reform. Still, most long-term observers recognize that in order to address cost, efficiency and quality, major progress will need to be made in reducing the number of uninsured persons. Reducing and eliminating the number of persons without health care coverage is an essential element in addressing many of the inefficiencies and costs in the current system, including those that result from uncompensated health care costs and cost-shifting to other purchasers because of services provided to uninsured and underinsured persons, inadequate access to timely primary, preventive and specialty health care for many people and the use of expensive emergency and inpatient services that might otherwise be avoided through improved and timely access to care.

This background paper is focused on the current state of coverage in California and strategies and opportunities for health care reform, beginning with a discussion of coverage, but with acknowledgement of the broader challenges facing the health care financing and delivery system.

I. CALIFORNIA'S UNINSURED

According to the California HealthCare Foundation (CHCF),^{*} over the past 20 years, the percent of uninsured Californians under age 65 has continued to rise as employer-sponsored health insurance has declined.¹ CHCF reported that between 1987 and 2007, employer-sponsored

^{*} **Data Note:** There are two primary data sources profiling the nature and extent of California's uninsured population: a data set developed by the Employee Benefit Research Institute's analysis of the U.S. Bureau of the Census Current Population Survey, on which CHCF relies, and a data set developed by the UCLA Center for Health Policy Research based on the annual California Health Interview Survey. The resulting number and type of data available vary slightly between the two data sets, but the broad profile and conclusions drawn, and the trends observed over time, are essentially consistent and compatible.

coverage in California declined by almost 8%. Although CHCF found that increased enrollment and eligibility for Medi-Cal (California's Medicaid program), and growth in individually purchased coverage, partially offset the decline in employer-sponsored coverage, more than 20% of Californians under age 65 remained uninsured during some part of 2007. CHCF found that from 2000 to 2007, the likelihood of being uninsured rose for all age groups, except children aged 20 and under, and the near elderly, those aged 55-64. During this period, CHCF reports that the largest increase of uninsured persons has come in the 45 to 54 age group.

The problem, though national, is more prominent in California, which has a lower percentage of individuals with employer-sponsored coverage and a higher proportion of uninsured. California has the eighth largest proportion of uninsured in the nation. Because of California's large population, the number of people without insurance during some part of the year — 6.6 million — is the highest of any state. Of the uninsured in California, 5.3 million were adults and 1.3 million were children.

CHCF reported findings also reveal:

- Sixteen percent of California's uninsured are children and 70% of uninsured children are in families where the head of the household has a year round, full-time job;
- Workers in private businesses of all sizes are experiencing an increased likelihood of being uninsured, although the percentage of uninsured workers is most pronounced in businesses with fewer than ten employees;
- Sixty-nine percent of uninsured families in California have incomes below \$50,000, 38% have family incomes below \$25,000, and 54% of the uninsured have annual incomes below 200% of the Federal Poverty Level (FPL) (\$18,310 for a family of three in 2009);² and,
- Nearly 60% of the uninsured in California are Latino. However, unlike Latinos, whose high rate of being uninsured (30% in 2007) has slightly declined over the last seven years, the likelihood of being uninsured increased during the same period for African Americans, Whites and Asians.

Potential Impact of the Current Economic Slowdown. In light of the current economic downturn in California and nationally, the ranks of the uninsured can be expected to grow as individuals who are laid off or experience reduced work hours lose employer-sponsored health coverage. Losing a job often means losing health insurance for the worker and the family. In considering the potential impact of the declining economy, a recent Kaiser Family Foundation (KFF) report estimated that an increase in the national unemployment rate from 4.6% to 7% would result in 5.9 million Americans losing employer coverage, an additional 2.4 million individuals on public programs and an additional 2.6 million uninsured, a 6% increase in the number of uninsured nationally.³ The report estimated that at 10% unemployment nationally, 13.2 million people would lose employer coverage, 5.4 million would be added to public programs, and the number of uninsured would increase by 5.8 million, or 13%. By way of illustration, California's current unemployment rate is 10.1%. Using the KFF estimates, if California experienced a 13% increase in the number of uninsured over the 2007 levels, the latest year for which data is available, an

additional 858,000 Californians could become uninsured as a result of the current economic crisis. This magnitude of increase means that California's current number of uninsured could be well above 7 million.

II. CURRENT SOURCES OF HEALTH CARE COVERAGE

The vast majority of Californians who do have health coverage obtain coverage through their employer or as dependents of an employee. Fifty-seven percent of Californians have employment based coverage; 16% get coverage through state public programs, such as Medi-Cal and the Healthy Families Program (HFP); 3.3% through federal coverage programs, Medicare and veteran's coverage programs; and, an estimated 8.7% purchase coverage through the private individual insurance market. CHCF also reports that the sources of coverage shifted among Californians during the period 1987–2007. Employer-sponsored coverage declined as a source of coverage from 64.6% to 56.7%, while government-sponsored coverage increased from 15.7% to 18.4% and individually purchased coverage increased from 6.8% to 8.0%. During that time, the percentage of uninsured increased from 17.6% to 20.2%.

Employer-Sponsored Coverage

According to CHCF, over the three-year period 2005-2007, an estimated 17.9 million Californians were covered by employer-sponsored health coverage, 9.2 million as employees (51%) and 8.7 million (49%) as dependents. However, there are differences in the availability of job-based coverage offered by employers. While only 59% of employers with 3-9 employees offer coverage, large employers above 200 employees approach 99-100% that offer coverage.⁴ The probability of California firms offering coverage also varies widely by workforce and wage characteristics. While 76% of higher-wage firms offer coverage, only 27% of low-wage firms offer coverage. Firms with many part-time workers offer coverage at a lower rate (53%) than firms with fewer part-time workers (71%).

Existing Public Coverage

The Governor's 2009 Budget estimates 942,000 children will be enrolled in HFP by June 30, 2010, and approximately 7.1 million individuals will be enrolled in Medi-Cal on that date. The 2007 California Health Interview Survey conducted by the UCLA Center for Health Policy Research found that, of the individuals who were uninsured *at the time of the survey*, 683,000 were children and 4.1 million were adults.⁵ Slightly over one half (56%) of the 683,000 children were eligible for either Medi-Cal or HFP, but only 6.6% of adults were eligible for Medi-Cal.

As a result of case law, and state and federal laws, eligibility rules for Medi-Cal are complex and based on multiple factors primarily related to income, property, household composition, residency, age and/or health condition. There are currently more than 170 "aid codes," or eligibility categories, in Medi-Cal. Generally speaking, low-income citizen children are eligible for Medi-Cal as follows: infants in families with incomes less than 200% FPL; one to five year olds at 133% FPL or less; and, six to 18 year olds at 100% FPL or less. Low-income adults can be eligible for Medi-Cal under a variety of programs primarily designed for disabled persons. Generally speaking, adults between the ages of 21 and 65, without children, who are not

pregnant, blind or, disabled, and who do not have one of several specific health care needs outlined in statute (such as dialysis, tuberculosis, breast and cervical cancer treatment, etc.) are not currently eligible for Medi-Cal. Federal Medicaid funds are not available for full coverage of undocumented persons in Medi-Cal.

HFP currently covers children in families with incomes that are less than or equal to 250% FPL but too high to qualify for Medi-Cal, (except for children up to age 2 born to women enrolled in the Access for Infants and Mothers Program). HFP applies income deductions that are applicable to children for Medi-Cal purposes in determining that a family's income does not exceed 250% FPL for purposes of HFP eligibility. Federal State Children's Health Insurance Program (SCHIP) funds are not available for full coverage of undocumented children in HFP.

Individually Purchased Coverage

While the majority of those with health insurance obtain that coverage on the job, individual coverage is the main alternative for those not covered through employment and who are ineligible for publicly subsidized health coverage. CHCF reports that, over the three-year period 2005-2007, an estimated 2.8 million people in California were covered in the individual health insurance market. According to CHCF, the costs of coverage and care represent a large share of income in this market.⁶ In 2006, CHCF found that a single person with median household income (\$30,623) buying coverage in the individual market would have spent 16% of income on health care expenses. In addition, those purchasing coverage through the individual market bear a greater share of the costs of care. Insurance covered 54.6% percent of a typical consumer's medical bills in the individual market, compared to 83.3% of costs for those covered by a plan through a small employer group. For those individuals with chronic conditions, annual out-of-pocket medical expenses are high. For example, CHCF found that in 2006, a person with diabetes spent an estimated \$3,275 — above and beyond the health insurance premium — if covered through the individual market, compared to \$1,101 if covered through a small group.

According to the Kaiser Family Foundation (KFF), the individual insurance market can be a difficult place to buy coverage, especially for people who are in less-than-perfect health. Access to and the cost of coverage is very much dependent on a person's health status, age, place of residence, and other factors. Common circumstances leading people to seek such coverage include self-employment, early retirement, working part-time, divorce or widowhood, or "aging off" a parent's policy. Insurance carriers in the individual market often decline to cover people who have pre-existing medical conditions, and even when they offer coverage, frequently impose severe limitations on the coverage for any expenses related to the pre-existing condition or charge more to individuals because of their medical history. This can price insurance out of the reach of many consumers in poor health or create significant gaps in coverage for individuals who end up with exclusions related to prior illnesses or very limited benefits.

III. OPTIONS AND APPROACHES FOR EXPANDING HEALTH CARE COVERAGE

A wide range of policies and strategies, and combinations of specific strategies, to cover the uninsured have been put forward at both the state and federal levels. The proposals range from

incremental changes to major restructuring of the health care system.

At the state level, states have considered and implemented a variety of strategies.⁷ In an effort to expand access to coverage, many states have sought waivers from the federal Centers for Medicare and Medicaid Services to expand their Medicaid and/or SCHIP programs to populations that typically are not eligible to receive benefits. States have also focused on strategies designed to lower the effective price of coverage, either by making reduced-price coverage available or by providing subsidies or incentives for the purchase of private insurance. Other strategies that states have used include reinsurance (discussed below), high-risk pools, broadening requirements for dependent coverage, and group purchasing arrangements.

Increasingly, policymakers have come to understand that the challenges states face in reforming health care cannot be addressed simply by focusing on coverage and access issues. However, there is also increasing recognition that coverage expansions are necessary to have an effective and efficient health care system.⁸ Consequently, many states are combining coverage expansions with strategies aimed at improving the health care delivery and financing system while controlling costs as well. Likewise, states are demonstrating an increasing awareness that reform efforts targeted to cost containment can also promote healthy behaviors and more effective management of chronic conditions.

In *Approaches to Covering the Uninsured: A Guide*, KFF suggests that the variety of policy strategies and approaches to solving the problem of the uninsured can be organized into four categories, which may be proposed in some combination:

- Strengthen current coverage arrangements;
- Improve the affordability of coverage;
- Improve the availability of coverage; and,
- Change the tax treatment [or] financing of health insurance.⁹

Strengthening Current Coverage Arrangements

One approach to increasing the number of individuals with health insurance is to build on and expand one or more of the current sources of coverage. This approach would involve efforts to expand employment-based coverage, expansion of existing public coverage programs and/or potential reforms to strengthen the individual health insurance market.¹⁰

Build on Employment Coverage. According to KFF, there are two basic ways to build on the employment-based coverage system: mandates and incentives. Employer mandates require all employers (or some subset of employers) to offer health coverage to their workers.

Alternatively, rather than mandating employer coverage, either a pay or play, or an employer spending obligation, may require employers to pay a specified minimum amount toward employee health coverage or pay a similar amount to a designated public fund or program that will make health coverage available to workers. When states consider establishing employer health care obligations, the proposals must be crafted in the context of the federal Employee Retirement Income Security Act of 1974 (ERISA). ERISA generally allows states to regulate the business of health insurance but generally prohibits states from requiring employers to

provide health care coverage or specifying the benefits that must be provided by employers. ERISA has been the subject of a number of court decisions. ERISA presents complex legal considerations for states looking to include employer financing in initiatives to expand access to health care.

Financial incentives for employers to increase coverage usually take the form of tax credits, which offer subsidies for employers providing coverage. Financial incentives may be focused on assisting smaller or lower wage firms or targeted to employers who have not previously provided coverage. Targeting financial incentives for employer coverage necessarily involves consideration of how to balance the goal of expanding coverage with whether the incentives reward or penalize employers already contributing to the cost of employee health coverage.

Build on Public Coverage. Another way to build on the current sources of coverage is to expand existing publicly funded coverage programs. In California, the largest public coverage programs are Medi-Cal and HFP. Expansion of public programs at the state level builds on the existing state and federal infrastructure which already exists and has the potential to increase federal funding for the state's coverage effort. Expansions of coverage can increase income eligibility for groups that are currently covered, such as children, pregnant women, parents of covered children and/or low-income seniors and persons with disabilities. States can also consider development of federal Medicaid waiver programs that reduce or eliminate some of the categorical eligibility constraints in the federal program, allowing states to cover everyone at or below a certain income threshold. In addition to expanding eligibility, states may also implement outreach and enrollment strategies to increase the number of low-income eligible children and other groups who are eligible for the existing programs but not enrolled.

Build on Individual Private Coverage. The third approach to building on current sources of coverage is to enact reforms that strengthen the effectiveness of the individual private insurance market in meeting the coverage needs of uninsured persons. Individually purchased health insurance is currently the only source of coverage for those who do not have job-based coverage or who are not eligible for public coverage programs. The regulatory reform efforts affecting individual coverage attempt to address problems in the existing market. For example, the individual market is characterized by lack of availability or wide pricing differentials for those with pre-existing medical conditions or who are considered by health insurers to be potentially high-risk. The benefit offerings in the individual market are often complicated and difficult to understand, the coverage options may be less comprehensive for many and for many individual insurance products, there is a very low share of premium dollars that actually go to paying for medical services, as opposed to administrative costs and profits, compared to employer coverage.¹¹

Elements of individual market reform might include one or more of the following: guaranteed issue and renewal, requiring health insurers to offer and renew coverage without regard to the health status of the individual purchaser; rating requirements which limit or prohibit premium variations in the market based on factors such as age, gender, geography or health status; standardization of benefit designs and/or establishing minimum benefit levels that health insurers must offer; establishing minimum medical loss ratios (the percent of premium that must be spent on medical care); and/or establishing and funding separate coverage programs for high-risk

persons and persons with pre-existing conditions, sometimes referred to as a "high-risk pool." In California, the Major Risk Medical Insurance Program (MRMIP), administered by the Managed Risk Medical Insurance Board (MRMIB) serves as the health insurer of last resort for individuals denied private individual coverage.

Improving the Affordability of Coverage

According to KFF, no coverage expansion is feasible or sustainable if the affordability of coverage is not addressed.¹² While broad-based cost containment strategies, and an array of policies and programs to reduce health care costs and health care cost inflation, will likely be considered in any health reform effort, focusing on affordability as a way to cover more uninsured people generally leads to consideration of two basic strategies: subsidies for coverage and/or offering lower-cost coverage products.

Offer Subsidies. The most direct method for making coverage more affordable is to provide direct financial assistance to help individuals and families purchase coverage in the form of subsidies. According to KFF, the most common mechanisms proposed for subsidies are tax deductions, refundable tax credits, or direct subsidies. Subsidies can be made available to individuals based on income level, based on a sliding scale related to income, or calculated as a percent of premium for purchased coverage.

Offer Less Expensive Products. This strategy is to allow and/or facilitate the design and offering of less expensive insurance products. Generally speaking, health coverage products with lower premiums cover fewer benefits and require consumers to pay higher cost sharing in the form of deductibles, copayments, coinsurance and other out-of-pocket costs, including covering out-of-pocket the costs for health care services not covered in a more limited benefit plan. Understanding the impact that lower cost and lower benefit plans have on affordability of coverage necessarily requires consideration of the total out-of-pocket costs individuals will bear, including both premium payments and the cost-sharing elements of the plan.

Provide for Reinsurance. Another strategy to improve affordability of coverage is to provide some form of reinsurance, subsidy and/or pooling for high cost claims. The goal of reinsurance is to lower overall health insurance premiums by subsidizing in some way, such as direct state subsidy, purchase of reinsurance, or pooled payments across all purchasers, the costs associated with high cost individuals and catastrophic cases. The concept of reinsurance flows from the persistent data which shows that a very small proportion of any population (10-20%) accounts for the bulk of health care costs (80-90%), regardless of source and type of coverage. Higher costs are generally incurred by the health care system for persons with debilitating and often multiple chronic illnesses, people with cancer, premature babies or individuals with other life-threatening diseases, people needing end-of-life care and victims of terrible accidents.

Improve the Availability of Coverage

In order to ensure broad coverage, health insurance must be readily available as well as affordable. Generally speaking, large employers are able to purchase or provide health care coverage for their workers, but the markets for small employers and individuals present barriers

to affordability and, in the case of the individual market, many potential buyers will be locked out of the market entirely because of their health status or prior claims history.

Create Or Provide Access To Large Purchasing Pools. One way to address the problems of availability and affordability of coverage, particularly for small employers and individuals, is to establish new or provide access to existing large purchasing arrangements. These arrangements have many names: purchasing cooperatives, exchanges, pools, or connectors. Purchasing cooperatives may be proposed on a state, regional or national basis. The idea is that the cooperatives arrange for or offer coverage for all eligible employers and individuals and by virtue of the number of purchasers buying together are better able to negotiate or offer lower prices than small employers or individuals might obtain on their own.

Mandate Individual Coverage. One way to ensure individuals have coverage is to establish a legal requirement that every resident obtain adequate private health insurance coverage, typically referred to as an individual mandate. Proponents of the individual mandate argue that mandates respond to a legitimate concern about "free riders," uninsured persons who nonetheless receive treatment when they get sick, in emergency rooms and through other uncompensated or reduced cost care, resulting in additional costs being passed on to taxpayers, purchasers and individuals with insurance. Proponents argue that those most likely to go without health insurance are the young and relatively healthy and that for these young, healthy individuals, going without health insurance is often a logical economic decision. The problem with their choice, proponents argue, is that it leads to a form of adverse selection. Allowing the young and healthy to stay out of the insurance pool typically results in higher insurance premiums for those who do buy coverage because the remaining insurance pool is older and more costly to insure. Finally, proponents argue that in the context of an individual mandate it is possible to impose stricter rules on insurance carriers, such as requiring them to guarantee issue of coverage to everyone, because concerns about potential adverse selection are reduced.

Opponents of an individual mandate argue that individuals, including young and healthy persons, are most likely uninsured because they cannot afford to buy meaningful coverage or are being denied private coverage because of pre-existing health conditions. Opponents argue that imposing a mandate does nothing by itself to significantly improve affordability and that the majority of uninsured persons will need some form of subsidy or government-sponsored health plan in order to comply with a mandate. Mandate opponents argue that requiring individuals to buy coverage on their own is inefficient, does not have the same tax advantages otherwise available for employer coverage, has higher selling costs and reduces the purchasing clout typically associated with buying group health insurance. Opponents are also concerned that a mandate can only be enforced through punitive and costly penalties or expensive government bureaucracies that come at the expense of the programs that actually provide health coverage. Finally, some opponents of the mandate view the requirements as unacceptably providing the health insurance industry with a captive market that must seek out and purchase their product.

Expand High-Risk Pools. Another strategy KFF identifies as a way to reform the underlying individual market and improve the availability of coverage is to establish or build on high-risk pools. High-risk pools currently operate in 34 states, including California, and provide health coverage to individuals considered medically uninsurable (or who meet other eligibility

requirements) and who are generally unable to purchase private individual coverage. Theoretically, allowing insurers to exclude such individuals from coverage keeps average premiums in the remaining market lower, while still ensuring that those who are most likely to need protection have a viable coverage option.

California's program for medically uninsurable persons, MRMIP, provides individual coverage through private health plans for those whose applications for private individual coverage are rejected by health insurers because of the individual's health history or health status. MRMIP is administered by the MRMIB, which also administers HFP. MRMIP subscribers pay relatively high premiums, which are set in statute at 125-137.5% of private market rates, and receive coverage that includes an annual benefit cap of \$75,000 per year. Premiums vary based on the age and region of the subscriber and the health plan they choose. MRMIP has served nearly 100,000 individuals since its inception in 1991 but, for much of that time, there has been a waiting list for the program. MRMIP premiums are subsidized through the Cigarette and Tobacco Surtax Fund (Proposition 99). Because the Proposition 99 appropriation (approximately \$40 million per year) is limited, the total number of individuals who can participate in MRMIP depends on available funding.

Change the Tax Treatment of Health Insurance

Most of the major policy choices related to the tax treatment of health insurance surround the way that the health benefits are treated for purposes of federal taxes. The federal tax code currently provides an incentive for employers and employees to arrange for health care coverage in the workplace because employer payments for health care are tax-deductible for employers and not treated as taxable income for employees. Since the 1950s, these tax incentives have encouraged and subsidized the employment-based insurance market, making it the dominant source of coverage. Among other things, the treatment of existing tax benefits for employer-sponsored coverage has been criticized as subsidizing employers and employees with the richest benefits and those at the highest incomes, while disadvantaging those without employer coverage who purchase coverage on their own and must pay full premiums with after-tax dollars.¹³ Incremental approaches to changing the tax treatment of health benefits include providing the same tax benefit for individual purchasers as those receiving employment-based coverage and capping the amount of employer benefits not subject to taxes.

Moving Away from an Employer-Based Coverage System

Another set of broader changes would move entirely away from the current employer-based delivery system for health care coverage.

One strategy toward that end would replace that tax preference for employer-sponsored coverage with a tax credit or tax deduction for individually purchased coverage. One advantage of this approach is that a refundable tax credit is available whether a person owes taxes or not and could be made available even for those who do not pay taxes and are at lower income levels.¹⁴ One potential disadvantage is that this approach relies on an individual health insurance market that has significant constraints and limitations, including notably higher administrative and marketing

costs, and the loss of group purchasing opportunities that can reduce premium costs.

Single-Payer Health Care. Single-Payer health care would essentially replace current sources of coverage and financing of health care for those under age 65 with a government-organized plan, funded in whole or in part through public financing. Instead of financing health care through employer and employee premiums, Single-Payer health care proposals generally assume funding through income, payroll and other general taxes. Proponents of Single-Payer argue that such a plan would guarantee coverage for everyone, and provide coverage in a manner that would be more efficient, and less costly, than the present system. This approach is sometimes referred to as "Medicare for everyone." Generally speaking, Single-Payer health care anticipates that the government would finance the care, with the health care delivery system remaining largely private. In most Single-Payer proposals, private health insurers would be able to sell "add on" and supplemental coverage, but would otherwise be excluded from maintaining a private market for basic health insurance. As KFF points out, the transformation of the health care financing and delivery system envisioned by a Single-Payer approach would require major cultural and administrative shifts for government, providers, insurers and the public.

IV. RELATED LEGISLATION

- 1) AB 1314 (Jones) would require the Department of Health Care Services, in consultation with the Legislature, to develop and submit a waiver to the federal government that would accomplish various objectives, including but not limited to, expanding health care coverage to low-and moderate-income children and adults, reducing the number of uninsured and maximizing federal funds.
- 2) SB 1 (Steinberg) would: a) expand Medi-Cal and HFP eligibility to cover all children regardless of immigration status with family incomes at or below 300% FPL; b) established a HFP Buy-In Program for children in families with incomes above 300% FPL; c) establish various presumptive eligibility programs; and d) streamline enrollment and retention with the goal of keeping more children covered.
- 3) SB 56 (Alquist) would make legislative findings and declarations regarding health care coverage and would declare the intent of the Legislature to enact and implement comprehensive reforms in the state's health care delivery system, as specified.
- 4) SB 92 (Aanestad) would establish the Healthcare Restoration Act (Act), and would use tax credits, health savings accounts, reinsurance products, tort reform, and electronic medical records to make reforms to California's health care system. The Act also makes significant changes to Medi-Cal.
- 5) SB 810 (Leno) would establish the California Healthcare System to be administered by the newly created California Healthcare Agency under the control of a Healthcare Commissioner appointed by the Governor and subject to confirmation by the Senate. SB 810 would make all California residents eligible for specified health care benefits under the California Healthcare System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. SB 810 would

establish a Premium Commission to recommend premiums to support the program and remaining elements of the proposal would only become operative on the date the Secretary of California Health and Human Services notifies the Legislature, as specified, that sufficient funding exists to implement the program.

V. PREVIOUS LEGISLATION

- 1) AB 1 X1 (Nunez) of 2007 would have enacted the California Health Care Reform and Cost Control Act and created the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP), a state health care purchasing program to provide coverage to specified employees, individuals eligible for new expanded public coverage and individuals who would have been newly eligible for a tax credit to defray health insurance costs. AB 1 X1 would have also established various health cost containment measures and private insurance market reforms and included several financing elements that would have been subject to voter approval on the November 2008 statewide ballot. AB 1 X1 failed passage in the Senate Health Committee.
- 2) AB 8 X1 (Villines) of 2007 proposed multiple, diverse strategies to address health care costs and access, including: tax incentives and government programs to promote and facilitate consumer-directed health care and employer-sponsored insurance; allowing the sale of out-of-state health plans and policies not subject to any California law or regulation; increasing Medi-Cal provider reimbursement rates and creating an income tax credit for physicians who provide unreimbursed care for the uninsured; establishing a mechanism for financial aid for training physician assistants; and, requiring foundation conversions to provide direct medical care. AB 8 X1 failed passage in the Assembly Health Committee in November 2007.
- 3) AB 1 (Laird and Dymally) and SB 32 (Steinberg), two similar bills introduced in 2007, would have: a) expanded Medi-Cal and HFP eligibility to cover all children regardless of immigration status with family incomes at or below 300% FPL; b) established a HFP Buy-In Program for children in families with incomes above 300% FPL; c) established various presumptive eligibility programs; and streamlined enrollment and retention with the goal of keeping more children covered. Both bills passed the Legislature but were not sent to the Governor.
- 4) AB 2 (Dymally) of 2007 would have revised and restructured MRMIP, which provides subsidized individual health care coverage for medically uninsurable persons. AB 2 would have secured additional funding and coverage for MRMIP-eligible persons by requiring all health plans and health insurers selling individual coverage in the state to accept assignment of such persons or to support the costs of MRMIP through a per person fee on individual health plan contracts and policies. AB 2 would also have enacted specified program changes related to eligibility, benefits and program administration. AB 2 was vetoed by Governor Schwarzenegger.
- 5) AB 8 (Nunez) of 2007 would have established the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) as a state purchasing pool administered by MRMIB, to negotiate and contract with health plans and health insurers to provide health insurance for

employees (and their dependents) of employers who elected to pay a fee to the state in lieu of making expenditures for health care for their employees equal to a specified percent of wages paid by the employer. AB 8 excluded very small and low-income employers. AB 8 also would have extended coverage to parents and children under 300% FPL through Medi-Cal and HFP, and covered the children regardless of immigration status. Finally, AB 8 included health insurance market reforms, uniform benefit designs and specific cost containment strategies. AB 8 was vetoed by Governor Arnold Schwarzenegger.

- 6) SB 48 (Perata) of 2007 would have established the Health Insurance Connector as a health insurance purchasing pool administered by MRMIB, and would have required employers to spend a designated amount on health care for employees or elect to have that health coverage provided through the Connector. SB 48 mandated that all employed persons have health insurance either through their employer or purchased on their own. The mandate covers all workers and their families. SB 48 would have extended coverage to parents and children under 300% FPL through Medi-Cal and HFP and included health insurance reforms in the state purchasing program and numerous cost containment strategies. SB 48 was amended to deal with another subject.
- 7) In 2007, Assembly Republicans introduced a 17 bill package of proposed reforms that included access to health savings accounts, decreased regulation of insurers, fewer insurance mandates, and a state insurance exchange for individuals, expanded state tax deductions for medical expenses, and combined health and workers compensation insurance policies. Eight of these bills were not heard at the authors' request. Of the remaining bills, two were passed by the Assembly, AB 1559 (Berryhill), Chapter 712 of 2007, which expands nursing education programs, and AB 1304 (Smyth), related to seismic upgrades of hospitals, which was not heard in Senate Health Committee at the request of the author.
- 8) In 2007, Senate Republicans introduced a series of bills and a reform plan that would have relied on tax incentives, redirection of existing health program funding and increased availability of community and primary care clinics to expand access to health care. The proposals included seeking voter approval to redirect existing tobacco tax revenues away from existing programs to children's coverage and would have reduced Medi-Cal benefits with the stated goal to make them more like what employed persons have in their job-based coverage; increased Medi-Cal provider rates over eight years; and reduced regulation of health insurance carriers to allow greater flexibility in the health insurance market.
- 9) SB 840 (Kuehl) of 2007 would have created the California Healthcare System (CHS), a Single-Payer health care system, administered by the California Healthcare Agency established in SB 840, to provide health insurance coverage to all California residents. SB 840 would have required the CHS to become operative when the Secretary of Health and Human Services determined the Healthcare Fund established for the program had sufficient revenues for implementation. SB 840 was vetoed by Governor Schwarzenegger.
- 10) SB 1014 (Kuehl) of 2007 would have funded the health care system proposed in SB 840 (Kuehl) through income, self-employment, and payroll taxes. No vote was taken on SB 1014

in the Senate Revenue and Taxation Committee.

- 11) SB 840 (Kuehl) of 2006, a Single-Payer bill, was vetoed by Governor Schwarzenegger. In his veto message, the Governor argued that SB 840 would result in an extraordinary redirection of public and private funding and a vast new bureaucracy, and that the preferable approach would be to promote personal responsibility and to build on the private and public systems already in place.
- 12) SB 921 (Kuehl), introduced in 2003, would have established a Single-Payer health care system in California. SB 921 passed the Senate and the Assembly Health Committee and died in the Assembly Appropriations Committee.
- 13) SB 2 (Burton), Chapter 673, Statutes of 2003, enacted the Health Insurance Act of 2003, a "pay-or-play" approach, to provide health coverage to employees (and in some cases their dependents) who do not receive job-based coverage and who work for large and medium employers. SB 2 was repealed by Proposition 72, a voter referendum on the November 2004 ballot.

SOURCES

¹ *Snapshot of California's Uninsured*, California HealthCare Foundation, December 2008, obtained on-line at www.chcf.org.

² Department of Health and Human Services, *2009 Poverty Guidelines*, Published in the Federal Register: January 23, 2009, (Volume 74, Number 14).

³ Holahan, J and Bowen Garrett, A, *Rising Unemployment, Medicaid and the Uninsured*, Kaiser Commission on Medicaid and the Uninsured, January 2009, obtained on-line at www.kff.org.

⁴ California Employer Health Benefits Survey, California HealthCare Foundation, December 2008, obtained on-line at www.chcf.org.

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